1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07699

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09171

1. DECEASED-NAME (Type or Print) First: Jadie Middle: Rounds Last: Ayers

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: May Day: 30 Year: 1969

2b. HOUR: 9P M

3. SEX: F

4. RACE: Negro

5. DATE OF BIRTH: Dec 18 1896

6. AGE (In years last birthday): 92 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD Month: May Day: 30 Year: 1969

2d. HOUR: 9P M

7a. BIRTHPLACE (State or foreign country): Md

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Worcester Md.

10. CITY OR TOWN OF DEATH: Berlin

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R3 Box 193 Branch St

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: —

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: Wor.

13c. CITY OR TOWN: Berlin

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: R3 Box 193 Branch St.

14. FATHER'S NAME First: Israh Middle: Waters Last:

15. MOTHER'S MAIDEN NAME First: Rosie Middle: G. Last: Collick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ✓ (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 215-12-6613

17. INFORMANT: Mrs Grace R. Ayers, daughter ADDRESS: R3 Box 193 Branch St Berlin Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F. J. Townsend Jr. M.D.

EXAMINER'S NAME (Type): F. J. Townsend, JR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town or county): Ocean City Md

22b. DATE SIGNED: May 31, 69

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 6-3-69

23c. NAME OF CEMETERY OR CREMATORY: Mt. Wesley

23d. LOCATION (City or Town) (County) (State): Snow Hill Worc - Md

24. FUNERAL DIRECTOR: Loretta E. Jolley ADDRESS: Jersey Rd #2 Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: JUN 10 1969

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A1SME (5)
10M REV. 1/68

4124

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2
2

FOR STATE HEALTH DEPT.

07700

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07689

1. DECEASED-NAME (Type or Print) First: Daniel Middle: Edward Last: Brittingham		2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 5 Day 13 Year 1969	2b. HOUR 9 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-3-98	6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
2c. DATE PRONOUNCED DEAD Month 5 Day 13 Year 1969	2d. HOUR 10:3 PM		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Berlin R.D. 3	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.D. 3	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farm Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Farming
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Berlin	13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET AND NUMBER: R.D. 3
14. FATHER'S NAME First: John Middle: William Last: Brittingham		15. MOTHER'S MAIDEN NAME First: Jennie Middle: Last: Massey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-32-6800	17. INFORMANT: (Sister) ADDRESS: Mrs. Webster Colbourn Frankford, Del.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocarditis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ?

428 X

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocarditis

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] & Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Clifford E. Schott M.D.

EXAMINER'S NAME (Type): Clifford E. Schott, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X] Acting

22b. DATE SIGNED: 5-14-69

ADDRESS (Street, city, town, or county): Worcester

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5-15-69	23c. NAME OF CEMETERY OR CREMATORY: Evergreen	23d. LOCATION (City or Town) (County) (State): Berlin Wor. Md.
24. FUNERAL DIRECTOR: Anna A. Burbage	ADDRESS: Berlin, Maryland	25a. REC'D BY REGISTRAR DATE MAY 19 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07701

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07690

1. DECEASED-NAME (Type or Print): First JULIA; Middle ELLEN; Last HANCOCK

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month MAY Day 19 Year 1969

2b. HOUR 6:00 A.M.

2c. DATE PRONOUNCED DEAD: Month May Day 19 Year 1969

2d. HOUR 8:00 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 8-25-1966

6. AGE (In years last birthday): 2 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Pocomoke City

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 204 Fourth Street

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): none

12b. KIND OF BUSINESS OR INDUSTRY: --

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission): STATE Virginia

13b. COUNTY --

13c. CITY OR TOWN: Richmond

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 205 South Bldv. Apt. 11

14. FATHER'S NAME: First William; Middle John; Last Hancock

15. MOTHER'S MAIDEN NAME: First Mary; Middle Elaine; Last Evans

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): --

16b. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Mary Elaine Hancock, ADDRESS: Richmond, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration of mucous and blood — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) tracheobronchitis, secondary to tracheotomy — 1 day

DUE TO, OR AS A CONSEQUENCE OF

(c) Papilloma of larynx

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.

2121

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: April 6, 1969

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Papilloma of larynx

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Lloyd O. Long M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: 5-20-69

EXAMINER'S NAME (Type): Lloyd O. Long, M. D., 104 Bay Street, Snow Hill, Md. (ADDRESS (Street, City or Town) (County) (State)) Worcester

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5-21-1969

23c. NAME OF CEMETERY: Presbyterian

23d. LOCATION (City or Town) (County) (State): Pocomoke City-Wor.-Md.

24. FUNERAL DIRECTOR: Robert H. Watson, ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR: MAY 23 1969

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15ME (5) 10M REV. 1/68

Robert H. Watson

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07702

CERTIFICATE OF DEATH

07692

1. PLACE OF DEATH
a. COUNTY: WORCESTER MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN RURAL
c. LENGTH OF STAY IN 1b: 76 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL BERLIN
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD Middle R. Last JARVIS
4. DATE OF DEATH: Month MAY Day 7 Year 1969
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 14, 1893
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (County & State, or foreign country): WORCESTER-BERLIN-MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: THOMAS JARVIS
14. MOTHER'S MAIDEN NAME: SARAH COFFIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WORLD WAR I
16. SOCIAL SECURITY NO.: 219-01-0718
17. INFORMANT: THOMAS K. TAYLOR Address: BERLIN, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerotic Heart Disease — several years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4123

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic pulmonary emphysema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 12, 1969 to May 7, 1969, that (I) (we) last saw the deceased alive on May 7 1969, and that death occurred at 4 P.M. from causes and on the date stated above.

22a. SIGNATURE: Lloyd O. Long M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 12, 1969
22c. PHYSICIAN'S NAME (Type): Lloyd O. Long, M.D.
22d. ADDRESS: 104 N. Bay St., Snow Hill, Md. 21863

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 10, 1969
23c. NAME OF CEMETERY OR CREMATORY: ST. PAULS
23d. LOCATION (City or Town) (County) (State): BERLIN WORCESTER Md.
24. FUNERAL DIRECTOR: Anna A. Burbage ADDRESS: Berlin Md.
25a. REC'D BY REGISTRAR DATE: MAY 16 1969
25b. REGISTRAR'S SIGNATURE: Willard Hodges

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07703

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07693

1. DECEASED-NAME (Type or Print) First: RAYMOND Middle: JOHN Last: KERSH				2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month 5 Day 1 Year 1969	2b. HOUR 7:00 A.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-22-1908	6. AGE (in years last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month 5 Day 1 Year 1969	2d. HOUR 8:30 A.M.

7a. BIRTHPLACE (State or foreign country): Washington
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Pocomoke City
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.F.D. 2
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired-U.S.Army
12b. KIND OF BUSINESS OR INDUSTRY: Military

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: R.F.D. 2

14. FATHER'S NAME First: John Middle: Raymond Last: Kersh
15. MOTHER'S MAIDEN NAME First: Marie Middle: -- Last: LA Brot

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW 2
16b. SOCIAL SECURITY NO.: 532-07-7952
17. INFORMANT: Mrs Gettine Kersh ADDRESS: Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIO SCLEROTIC HEART DISEASE — UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert C. La Mar M.D.
EXAMINER'S NAME (Type): Robert C. La Mar
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): 104 Bay Street, Snow Hill, Md.
22b. DATE SIGNED: 5-1-69

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5-3-1969
23c. NAME OF CEMETERY: St. Mary Episcopal
23d. LOCATION (City or Town) (County) (State): Pocomoke City-Wor.-Md.

24. FUNERAL DIRECTOR: Robert H. Watson ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: MAY 5 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert H. Watson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

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07704

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07694

1. DECEASED-NAME (Type or print) First: Harley Middle: Bowen Last: Morris	2a. DATE OF DEATH Month Day Year: May 2, 1969	2b. HOUR: 8A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 3, 1891	6. AGE (In years last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Bishopville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): At home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Poultryman	12b. KIND OF BUSINESS OR INDUSTRY: Chicken
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Bishopville	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last: Levin J. Morris		15. MOTHER'S MAIDEN NAME First Middle Last: Sallie W. Walker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): Yes (If yes give war or dates of service): World # 1	16b. SOCIAL SECURITY NO.: 214-34-5392	17. INFORMANT Address: Ida Morris Bishopville, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of lung — 1 year

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from Sept. 5, 1963, to May 2, 1969, that (I) (we) last saw the deceased alive on Apr. 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jack C Lewis MD DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 5-3-69	
22d. PHYSICIAN'S NAME (Type): Jack C. Lewis, M. D.	22e. ADDRESS: Selbyville, Delaware		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 5, 1969	23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows	23d. LOCATION (City or Town) (County) (State): Bishopville Md.	
24. FUNERAL DIRECTOR: Peter W. Haley	ADDRESS: Selbyville Del.	25a. REC'D BY REGISTRAR DATE: MAY 7 1969	25b. REGISTRAR'S SIGNATURE: Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1968

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07695

1. DECEASED-NAME (Type or Print): First Daisey Middle B. Last Roberts

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month May Day 21 Year 1969

2b. HOUR M

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH: Apr. 17, 1892

6. AGE (In years last birthday): 77 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month May Day 21 Year 1969

2d. HOUR M

7a. BIRTHPLACE (State or foreign country): Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Worcester Md.

10. CITY OR TOWN OF DEATH: Pocomoke

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rural - Pocomoke

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer

12b. KIND OF BUSINESS OR INDUSTRY: Factory

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Worcester

13c. CITY OR TOWN: Pocomoke

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: R.F.D. 2 Bx. 372

14. FATHER'S NAME First Samuel Middle Beauchamp Last

15. MOTHER'S MAIDEN NAME First Unknown Middle Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —

16b. SOCIAL SECURITY NO.: 219-07-0514

17. INFORMANT: Juanita Teagle ADDRESS: R.F.D. Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIO SCLEROTIC HEART DISEASE — YRS
DUE TO, OR AS A CONSEQUENCE OF
(c)

4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Robert Lamar M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 5-21-69

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5-25-69

23c. NAME OF CEMETERY OR CREMATORY: St James Cem.

23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.

24. FUNERAL DIRECTOR: Samuel Lang ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: MAY 26 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 10M REV. 1/68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07706
Item23 Film G413 6/6/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07696

1

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Annie	Mae	Vickers	5	23	1969	11:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Feb. 17, 1888	81 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Worcester Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Whaleyville, Md.	Home	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Marhland	Worcester	Whaleyville,		RFD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward	Vickers		Sally Taylor		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
XX	XX	218-05-8585	Beulah Lewis	Whaleyville, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocarditis
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocarditis
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes.

2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1-1-69, 19____, to 5-23-69, that (I) (we) last saw the deceased alive on 5-31-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Clifford E. Schott					

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Clifford E. Schott M.D.	Berlin, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	5/27/1969	Dale	WHALEYVILLE	WORCESTER	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Peter Whaley	Selbyville, Del.	MAY 29 1969	Deputy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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